

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/02/2025
NAME OF PROVIDER OR SUPPLIER  Majestic Mountain Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  40131 Highway 49 Oakhurst, CA 93644	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow its transfer and discharge policy and procedure for one of three sampled residents (Resident 1) when the facility failed to comply with the legal requirements to notify the Resident 1 of the transfer or discharge, the reasons for the move in writing and in a language and manner they understand, develop and implement an effective discharge planning process that focuses on the resident's discharge goals and after the hospitalization, the facility refused to re-admit Resident 1 in accordance with court order. This failure placed Resident 1 at risk for loss of safety, homelessness, and delay in care. Findings: During a review of Resident 1's admission Record (AR- a summary of information regarding a resident which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis for fusion of spine cervical region (surgical procedure that joins two or more bones in the neck to create a stable structure), functional quadriplegia (not able to move all four limbs but no damage to the brain or spinal cord), inflammatory spondylopathy (disease that causes pain, stiffness and inflammation to areas that attach to bones), chronic pain syndrome, spinal stenosis cervical region (condition in which the spinal canal puts pressure on the spinal cord and nerves). During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 6/17/25, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact. During a review of document titled, Department of Health Care Services Office of Administrative Hearings and Appeals, dated 11/7/25, the document indicated, . The appeal is granted [Facility Name] has not met the legal requirements to involuntary discharge [Resident 1]. Therefore, facility must follow the required procedures to appropriately discharge Resident. Resident was transferred to hospital and facility refused to readmit Resident. Facility is not excused from complying with the discharge requirements. before discharging a resident, a long term care facility must provide proper notice, identify and establish a legally permissible reason for the discharge, adequately document the reasons for the discharge in the medical record, and provide sufficient preparation and orientation to ensure a safe and orderly discharge from the facility. in this case, facility transferred Resident to hospital and has not actually discharged Resident to a location that can meet his needs. Facility must readmit Resident and find a suitable discharge location or coordinate a discharge to another location that can meet his needs. Therefore, coordinating a safe discharge does not stop in this case even though Resident is not in Facility. During a review of Resident 1's hospital note titled, Case Management Note, dated 11/10/25, the note indicated, . Social worker consulted with [Registered Nurse] and escalated barriers for discharge to [skilled nursing facilities-SNF] to Leadership team. Statewide search for long term care placement at a SNF has been sent out and there are no acceptance. [Patient] came from home with daughter and per patient, is refusing to return due to not having support. During an interview on 12/2/25 at 10:49 a.m. with the administrator (ADM), the ADM stated Resident 1 was not readmitted into the facility since the court order to readmit Resident 1 was ordered on 11/7/25. The ADM stated the facility was informed by the acute care hospital (ACH), where Resident 1 was staying, that Resident 1 would be admitted to another facility. During an interview on 12/2/25 at 12:00 p.m. with licensed vocational nurse (LVN) 1, LVN 1 stated the facility process for an unplanned discharge was for the facility to involve the assistance of the social services director (SSD). LVN 1 stated it was the SSD who would arrange to call resident or resident representative to follow up on the unplanned discharge. During an interview on 12/2/25 at 12:38 p.m. with the SSD, the SSD stated the facility had informed him of the granted appeal that ordered the facility to readmit Resident 1. The SSD stated the facility initiated a plan to readmit Resident 1 by ensuring there was a room and bed available. The SSD stated there were multiple concerns regarding Resident 1 being readmitted to the facility. The SSD stated he was informed by the ADM that Resident 1 was being transferred to another facility. During an interview on 12/2/25 at 12:58 p.m. with the ADM, the ADM stated the facility was preparing to readmit Resident 1 when the court order was received. The ADM stated there were concerns with Resident 1's return to the facility due to Resident 1's history of behaviors. The ADM stated the SSD was assisting the ACH for an alternate placement for Resident 1. The ADM stated the facility</p>		